PROCEDURE EDUCATION LITERATURE

$ 190.00

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. ***If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."***

Umbilical HERNIORRHAPHY Repair

Definition

The strongest supporting soft-tissue in the body is called "fascia." When there is a weakened area or defect in the fascia, it is termed a **hernia**, and its surgical repair a herniorrhaphy. Hernias can occur in different areas of the body but are most common in the inguinal (groin area) region. They are termed *inguinal hernias*. Another common site is around the umbilicus (navel) and is called an *umbilical or periumbilical hernia*. Women may have a fascial defect in the upper thigh/groin region termed a *femoral hernia*. There is another type of hernia referred to as an *incisional hernia*. This is a hernia that occurs in an area where fascia had been previously opened to do a surgery in the abdominal cavity.

Hernias may present as just a bulge in the area, or they can cause significant discomfort. Although not all hernias have to be repaired, some can cause significant problems. It is possible for other tissue (such as fatty tissue or the small intestines) to get caught in the hernia and strangulate (lose its blood supply).

There are several ways to repair a hernia that will depend on different factors:

- the location of the hernia
- the size of the hernia
- whether this is a first time hernia or a re-do (repeat) repair
- the strength or quality of your own tissue around the hernia

Hernias are usually diagnosed by physical examination and it is uncommon to need special X-rays referred to as a CT scan or MRI scan.

Preparation

As with any procedure in which anesthesia is administered, you will be asked not to eat or drink anything after midnight on the evening prior to your surgery. You may brush your teeth in the morning but not swallow the water. If you are on medications that must be taken, you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. The procedure will not be performed if you are currently taking, or have recently taken any medication that may interfere with your ability to clot your blood ("blood thinners, aspirin, anti-inflammatory medicines, etc..."). The most common of these medications are aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter). ***Please refer to the attached list and tell us if you took any of these within the past 10 days.*** If your new medication is not on the list, alert us immediately so that we may ensure optimal procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure

The type of anesthesia used will reflect the size and location of your hernia, your overall age and health, as well as your and your surgeon's preferences. The advantages and disadvantages of each type will have been discussed with you by your surgeon and by the anesthesiologist.

ORLANDO, FL 32886

DATE 9/25/09

RETURN SERVICE REQUESTED

ACCOUNT NUMBER 969828-02

PLEASE DIAL NUMBER AS SHOWN
OUR TOLL FREE PHONE NUMBER IS 1-866-622-5104

AMOUNT PAID $ _____

OUR PATIENT SERVICES WEBSITE IS: WWW.EMSCLAIMS.NET

969828-02
SHERIF KODSY
15968 LAUREL OAK CI
DELRAY BEACH, FL 33484

263

MAKE CHECKS PAYABLE IN U.S. DOLLARS TO:

PALM BEACH COUNTY FIRE RESCUE
PO BOX 862036
ORLANDO, FL 32886

969828-02 0

PATIENT NAME: SHERIF KODSY
PHONE NUMBER:

TRANSPORTED TO: DELRAY COMMUNITY

DATE	DESCRIPTION OF SERVICE	CHARGES	PAYMENTS
8/22/09	EMS TRANSPORT	490.00	
	MILEAGE CHARGE 0001.0 @ 009.00	9.00	

You are responsible for the emergency transport services itemized above. If you have insurance or participate in any program that will pay for these services, please complete the reverse side of this form and return it in the enclosed envelope. IF YOU HAVE MEDICARE COVERAGE, YOU MUST SIGN AND RETURN THE SIGNATURE SECTION IN ORDER FOR US TO SUBMIT A CLAIM TO MEDICARE ON YOUR BEHALF. PLEASE MAKE SURE THAT YOUR NAME APPEARS EXACTLY AS IT DOES ON YOUR MEDICARE CARD. IF YOU ARE COVERED BY A MEDICARE HMO, HMO, PLEASE INCLUDE THE NAME OF THE HMO AND YOUR POLICY NUMBER. You may also update your insurance information or enter a billing concern on the internet at www.emsclaims.net. Otherwise, payment is due within 14 days.

Thank you for your assistance.

PAY THIS AMOUNT 499.00

IMPORTANT NOTICE

IN ORDER FOR YOUR INSURANCE TO BE BILLED PLEASE PROVIDE THE REQUIRED INFORMATION REQUESTED ON THE REVERSE SIDE OF THE FORM AND SIGN THE TOP PORTION.

National Pain Institute
5365 W.Atlantic Ave.
Suite 504
Delray Beach, FL 33484
(561) 495-6300
www.natpain.com

PatientID: 21744
Patient Name: SHERIF KODSY
Date of Birth: 04/27/1964
Policy ID/Claim #: 085024081
Referring Physician: CARL SALVATI MD
Date of Service: 04/07/2009

RETURN VISIT - PREVIOUS PROBLEM

HISTORY OF PRESENT ILLNESS:

DATE OF INJURY: JULY, 1, 2008.

The patient is a pleasant, 45 year old, right handed, Caucasian, male.

CERVICAL SPINE: The patient presents with complaints of neck pain. The pain is located in the lower neck. The pain radiates into the right shoulder. The quality is achy. Patient states MRI of C-spine reveals HNP.

LUMBAR SPINE: The patient presents with symptoms of low back pain. The onset of pain began following an automobile accident where the patient was struck on the opposite side of the vehicle, restrained, and airbag deployed and his truck overturned onto the drivers side . The patient presents with complaints of pain in the lower back region. The pain radiates into the sacroiliac region bilaterally, left groin,left knee, left foot. The severity is moderate. The duration is continuous, variable. The quality is sharp. The symptoms were aggravated by sitting, standing, bending, carrying, lifting. EMG/NCS cw left L5 neuropathic findings, MRI L-spine cw a broad based central disc herniation at L34 and a small buldge at L5S1. He is having insomnia at this time.

CHANGES: Since last seen the patient has not had any new injuries, hospitalization or medication changes.

RESPONSE TO TREATMENT: The patient's present pain score is subjectively graded 6/10, to 7/10. The patients pain score is stable on the present medication regimen.

MEDICATION SIDE EFFECTS: The patient reports no adverse side effects from the present medication.

PAST MEDICAL HISTORY:

MEDICAL: No history of significant medical diseases.Prior MVA 20 years ago sustaining fracture to left leg with closed reduction for which he made a full recovery. WRI 4 years ago cutting a tendon in the right leg with repair and full recovery.

SURGICAL: Left shoulder arthroplasty. Biceps tendon repair.

CURRENT MEDICATION LIST:

PERCOCET ORAL TABLET 10-325 MG, 1 Every Six Hours, As Needed
PREVACID ORAL CAPSULE DELAYED RELEASE 15 MG, 1 Every Day
LYRICA ORAL CAPSULE CONVENTIONAL 75 MG, 1 Every Day At Bedtime

CURRENT ALLERGY LIST:

NKDA

FAMILY HISTORY:

GENERAL FAMILY ILLNESS: No significant familial diseases.

SOCIAL HISTORY:

ALCOHOL: Minimal alcohol consumption.
TOBACCO USE: Currently smokes 1 1/2 PPD, has smoked for 25 to 30 years.
MARITAL STATUS: Single.
OCCUPATION: General contractor

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ILLICIT DRUG USE: No history of illicit drug use or prescription misuse.

REVIEW OF SYSTEMS:
GENERAL: No major weight gain, loss or fever.
EYES: No loss or change in vision.
EARS/NOSE/MOUTH/ THROAT: No hearing changes, hoarseness, or swallowing difficulties.
RESPIRATORY: No shortness of breath, cough, hemoptysis, or wheezing.
CARDIAC: No chest pain, palpitations, tachyarrhythmias, or edema.
GI: No abdominal pain, change in bowel habits or heartburn.
GU: No urinary problems noted.
MUSCULOSKELETAL: See HPI.
NEUROLOGICAL: See HPI.
SKIN/CHEST WALL: No rashes, sores, blisters, growths, changing moles, discolorations or non-healing lesions. No abnormalities in chest wall.
PSYCHIATRIC: No recent change in mood or behavior.
ENDOCRINE: No heat or cold intolerance, change in hair distribution, excessive thirst, hunger, or urination, change in energy level, or significant weight gain or loss.
HEMATOLOGIC/LYMPHATIC: No abnormal bruising or bleeding. No swollen, tender, or painful lymph nodes.
ALLERGIC/IMMUNOLOGIC: No latex allergies or recurrent infections.

PHYSICAL EXAM:
CONSTITUTIONAL:
VITAL SIGNS:
VS-PULSE: 72 Left Radial, Regular
VS-BLOOD PRESSURE: 130/80 Left Arm Sitting
VS-PULSE OXIMETRY: 100%
GENERAL APPEARANCE: Well developed, well nourished. In no acute distress.
GENERAL EXAM:
RESPIRATORY: Normal respiratory effort with symmetrical lung expansion. Lungs clear to auscultation. No adventitious sounds noted.
CARDIOVASCULAR:
PALPATION & AUSCULTATION: Regular rate and rhythm with no murmurs, gallops, rubs or abnormal heart sounds.
ARTERIAL & EDEMA/VARICOSITIES: Pulses are 2+ and symmetrical. No edema. No varicosities.
CHEST: Chest normal to inspection and palpation, symmetrical with no chest deformity, tenderness, or masses.
ABDOMEN: The skin of the abdomen is normal. Protuberant abdomen secondary to generalized obesity. No hernias. Normal bowel sounds in all 4 quadrants. No masses. No tenderness.
MUSCULOSKELETAL EXAM:
CEREBRAL STATUS: Awake and alert. Oriented to person, place, time and general circumstances. Recent and remote memory intact. Able to give personal history. Knowledgeable of current events and past history. Vocabulary is normal.

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CEREBELLAR STATUS: Finger to nose and heel to shin normal bilaterally.
CRANIAL NERVES: CNs II-XII grossly intact.
GAIT/STATION: Gait intact.
POSTURE: Altered due to forward flexed body posture.
HEAD/CERVICAL SPINE/SHOULDER GIRDLE: No erythema, ecchymosis or edema. Mild tenderness in the bilateral paraspinal area overlying the facet joints. Head and neck in neutral position. Active flexion from 0 - 60 degrees, active extension from 0 - 45 degrees, active lateral bending from 0 - 30 degrees bilaterally, active lateral rotation from 0 - 60 degrees bilaterally. Normal stability. Normal strength and tone.
UPPER EXTREMITIES
LEFT UPPER EXTREMITY:
INSPECTION: No erythema. No ecchymosis. No edema. There are scars consistent with previous surgeries listed in HPI/PMH.
JOINT STABILITY: No shoulder instability or subluxation. No varus or valgus instability of the elbow. No joint instability of the digits.
RANGE OF MOTION:
SHOULDER RANGE OF MOTION: Forward flexion full and painless. Extension full and painless. Abduction full and painless. Internal rotation full and painless. External rotation full and painless. Horizontal adduction full and painless. Horizontal abduction full and painless.
ELBOW RANGE OF MOTION: Full painless active and passive range of motion from 0-160 degrees. Full painless active and passive supination to 90 degrees. Full painless active and passive pronation to 90 degrees.
WRIST RANGE OF MOTION: Normal range of motion at the wrist in all plains of motion.
FINGER RANGE OF MOTION: Normal range of motion of the thumb and all digits of the hand.
STRENGTH: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.
RIGHT UPPER EXTREMITY:
INSPECTION: No erythema. No ecchymosis. No edema.
JOINT STABILITY: No shoulder instability or subluxation. No varus or valgus instability of the elbow. No joint instability of the digits.
RANGE OF MOTION:
SHOULDER RANGE OF MOTION: Forward flexion full and painless. Extension full and painless. Abduction full and painless. Internal rotation full and painless. External rotation full and painless. Horizontal adduction full and painless. Horizontal abduction full and painless.
ELBOW RANGE OF MOTION: Full painless active and passive range of motion from 0-160 degrees. Full painless active and passive supination to 90 degrees. Full painless active and passive pronation to 90 degrees.
WRIST RANGE OF MOTION: Normal range of motion at the wrist in all plains of motion.
FINGER RANGE OF MOTION: Normal range of motion of the thumb and all digits of the hand.
STRENGTH: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.
LUMBAR SPINE/PELVIS: No erythema, ecchymosis, or edema. Moderate generalized tenderness in the lumbar facet area, moderate generalized tenderness in the sacral, coccygeal and pelvic areas. Normal lordotic

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Date of Service: 04/07/2009

curve. Active lumbar flexion from 0-35 degrees, Active lumbar extension from 0-5 degrees, pain elicited with active lumbar extension, Active lumbar lateral flexion from 0 -15 degrees bilaterally, the SI joints are restricted bilaterally. Normal strength and tone. Patrick Test positive on the left, Patrick Test positive on the right, Seated Straight Leg Raising Test negative, Supine Straight Leg Raising Test negative.

LOWER EXTREMITIES

LEFT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

RANGE OF MOTION: Range of motion of the hips, knees, ankles, and feet is within normal limits within all planes of movement.

HIP RANGE OF MOTION: Hip extension 30 degrees (normal). Hip flexion > 120 degrees (normal).

KNEE RANGE OF MOTION: Normal physiological flexion ROM for age and body habitus. Normal physiological extension ROM for age and body habitus. No extension lag.

FOOT/ANKLE RANGE OF MOTION: Full, painless dorsi/plantar flexion of the ankle. Full, painless subtalar inversion and eversion. Full, painless abduction and adduction of the transverse tarsal joint. Full, painless dorsi/plantar flexion of the hallux MTP. Full, painless range of motion of the lesser toes.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is normal. Normal muscle bulk (no atrophy). No fasciculations.

RIGHT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema. There are scars consistent with previous surgeries listed in HPI/PMH.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

RANGE OF MOTION: Range of motion of the hips, knees, ankles, and feet is within normal limits within all planes of movement.

HIP RANGE OF MOTION: Hip extension 30 degrees (normal). Hip flexion > 120 degrees (normal).

KNEE RANGE OF MOTION: Normal physiological flexion ROM for age and body habitus. Normal physiological extension ROM for age and body habitus. No extension lag.

FOOT/ANKLE RANGE OF MOTION: Full, painless dorsi/plantar flexion of the ankle. Full, painless subtalar inversion and eversion. Full, painless abduction and adduction of the transverse tarsal joint. Full, painless dorsi/plantar flexion of the hallux MTP. Full, painless range of motion of the lesser toes.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is normal. Normal muscle bulk (no atrophy). No fasciculations.

SENSATION:

SENSATION: Light touch sensation is within normal limits in all extremities. pinprick sensation is within normal limits in all extremities. Vibratory sensation is intact in all extremities. Joint proprioception is intact in all extremities.

DEEP TENDON REFLEXES: Deep tendon reflexes are 2+ and bilaterally symmetrical. Absent Babinski's bilaterally. Absent ankle clonus bilaterally.

PREVIOUS IMAGING REPORTS:

DIAGNOSIS:

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Policy ID/Claim #: 085024081
Referring Physician: CARL SALVATI MD
Date of Service: 04/07/2009

722.10-DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT at L34
723.1-CERVICALGIA
724.3-SCIATICA
The patient has completed a conservative course of treatment including PT, chiropractic care and medicinal management. He is not interested in pursuing any interventional treatment and at this point he should be considered at MMI. In accordance with my education, experience and with assistance of the AMA guides to evaluation of permanent impairment 6th edition he has sustained a PPI to whole person of 8% in regards to this most recent MVA.
847.2-LUMBAR SPRAIN AND STRAIN
847.3-SPRAIN AND STRAIN OF SACRUM

PLAN:

MEDICATIONS:

PERCOCET ORAL TABLET 10-325 MG, 1 Every Six Hours, As Needed, 120 Dispensed, status: NEW PRESCRIPTION, 04/07/2009.

LYRICA ORAL CAPSULE CONVENTIONAL 75 MG, 1 Every Day At Bedtime, 30 Dispensed, 1 Fills, status: DISCONTINUED, 4/7/2009 9:28:58 AM.

NEURONTIN ORAL CAPSULE CONVENTIONAL 300 MG, 1 Three Times A Day instructions week#1 one capsule qd, week#2 one capsule bid, week#3 one capsule tid, 90 Dispensed, status: NEW PRESCRIPTION, 04/07/2009.

AMBIEN ORAL TABLET 10 MG, 1 Every Day At Bedtime, 30 Dispensed, status: NEW PRESCRIPTION, 04/07/2009.

PHYSICAL THERAPY PRESCRIPTION / ORDERS: Massage therapy 1 time per week for 8 weeks
PATIENT EDUCATION: Discussed information on medications including but not limited to the indications, use, and possible side effects. Given the patient's diagnoses and persistent chronic pain they will continue to require high doses of opioid pain medications indefinitely to allow some quality of life and functional mobility.
WORK & ACTIVITY STATUS: Work status is full time sedentary work. Activity restrictions include bending at the waist, carrying more than 10 pounds, climbing, kneeling, lifting greater more 10 pounds, pulling, pushing, twisting motions at the waist. It is recommended that the restrictions are maintained indefinitely. He requires assistance for household chores including laundry, gardening, mopping, windows and other heavy duty cleaning.
RECOMMENDATIONS: Patient instructed to return in 2 months. Reason for return visit: to evaluate response to medication(s).

Electronically Signed by: Jeffrey A. Zipper, M.D. on Tuesday, April 07, 2009

National Pain Institute
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Suite 504
Delray Beach, FL 33484
(561) 495-6300
www.natpain.com

PatientID: 21744
Patient Name: SHERIF KODSY
Date of Birth: 04/27/1964
Policy ID/Claim #: XJWH64995950
Referring Physician: CARL SALVATI MD
Date of Service: 08/24/2009

Electronically Signed by: Jeffrey A. Zipper, M.D. on Monday, August 24, 2009

PRINTED BY: MariaGeribon
DATE: 1/27/2010

DISABILITY CERTIFICATE

RE: Sherf Kodsy
PATIENT'S NAME

DOL: 7/1/08
DATE OF ACCIDENT

I have examined and/or treated the above-named patient for injuries sustained in the above auto accident. As a result of the injuries received in this auto accident. , I HAVE DISABLED AND/OR RESTRICTED THE PATIENT FOR THOSE ACTIVITIES THAT ARE MARKED BELOW.

_____ WORK/EMPLOYMENT DISABILITY: The patient has been on work disability from _____ (Date) through _____ (Present or future date).

_____ ATTENDANT CARE: **The patient needs help taking care of their own personal needs, including, but not limited to dressing, grooming, medication dispensing, ambulating, bathing, toiletry and general hygiene, to supervision and observation.** It is my opinion that the patient required these services from _____ (Date) through _____ (Present or future date) for _____ (Hours per day) hours per day, _____ (Days per week) days a week due to the injuries sustained in MVA.

✓ _____ REPLACEMENT SERVICES/ HOUSE WORK: **Household chores and/or outdoor chores that involve bending, lifting, twisting, prolonged standing or any other activity that may affect the patients medical condition(s).** It is my opinion that the patient needs help with household chores, as a result of his injuries sustained in the MVA, from 10/7/08 (Date) through Present (Present or future date) indefinitely.

_____ TRANSPORTATION SERVICES: The patient is unable to drive and requires transportation service from _____ (Date) through _____ (Present or future date).

Date: 4/7/09

_____
DOCTOR'S SIGNATURE

Jeffrey Zipp M.D.
PRINTED DOCTOR'S NAME

STATEMENT

PLEASE REMIT PAYMENT TO:
OPEN MRI & CT OF S MIAMI
DBA:DELRAY DIAGNOSTICS
PO Box 550837
Tampa, FL 33655

LOCATION OF PROCEDURE:
Delray Diagnostics
101 N W 1st Ave
Delray Beach, FL 33444
Ph#: 561-272-4770

Account Number	17014
Statement Date	03/30/09
Due Date	04/30/09
Amount Remitted	

To: Mr. SHERIF KODSY
9393 LAUREL GREEN DR

BOYNTON BEACH, FL 33437

IF YOU NEED ASSISTANCE, PLEASE CALL
OUR LOCAL# (561-272-4770) TO DISCUSS
PAYMENT OPTIONS OR
POSSIBLE ADJUSTMENTS.

Date		Description	Charges	Payments	Adjust.	Deductible	Balance
08/26/08	72148	MRILUMBAR	$1,520.00				
12/04/08				$940.05			$235.01
12/04/08				$0.00	$344.94		
09/26/08	72192	CTPELVIS	$680.00				
12/04/08				$477.89			$83.01
12/04/08				$0.00	$119.10		
10/31/08	70553	MRIBRAINWW	$2,810.00				$2,810.00
11/12/08	72141	MRICERVICA	$1,515.00				$1,515.00

Messages:

Insurance Coverage PROGRESSIVE-FL , ATTNY: GINZBERG, DAVID ,

$4,643.02	$0.00	$0.00	$0.00	$4,643.02	$4,643.02	$4,643.02

Delray Diagnostics
101 N W 1st Ave
Delray Beach, FL 33444

Phone: 561-272-4770
Fax: 561-272-0811

To : CARL SALVATI, M.D.
13456 MILITARY TRAIL SUITE A
DELRAY BEACH, FL 33484
Fax: 561-495-5191

Name: SHERIF KODSY
MRN #: D0002378
Exam Start: 10/31/08 11:54 am

Phone: 561-737-8998
DOB: 04/27/1964
Gender: Male

Exam: MRI of the Brain With and Without Contrast
CPT Code(s): 70553 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENC
Laterality:
Clinical: HEADACHES

PROCEDURE: This study consists of a variety of pulse sequences acquired in multiple imaging planes which include the entire brain and upper cervical spine. Axial and coronal images were obtained both before and after intravenous contrast administration.

FINDINGS: Exam of the brain demonstrates a normal size and configuration of the ventricular system with no evidence of intracranial mass effect or hydrocephalus. Subarachnoid cisterns and cortical sulci are normal in size as well.

The brain parenchyma is entirely normal in appearance with no evidence of mass effect or alteration of signal intensity. The brain stem and cerebellum appear normal as well. Following intravenous contrast infusion, there are no abnormal areas of contrast enhancement within the brain.

Normal flow voids are demonstrated within the intracranial, vertebrobasilar, and carotid circulations.

Exam of the mastoids is normal. There is evidence of mucosal thickening and fluid levels of the paranasal sinuses. The orbits and optic nerves are well visualized and are normal in appearance. The pituitary is also normal in size and configuration. Both internal auditory canals have a normal symmetric appearance.

CONCLUSION: Sinusitis.

Otherwise normal MR examination of the brain with and without contrast enhancement.

Interpreting Radiologist

Delray Diagnostics
101 N W 1st Ave
Delray Beach, FL 33444

Phone: 561-272-4770
Fax: 561-272-0811

To : CARL SALVATI, M.D.
13455 MILITARY TRAIL SUITE A
DELRAY BEACH, FL 33484
Fax: 561-495-5191

Name: SHERIF KODSY
MRN #: DD002378
Exam Start: 9/26/08 2:27 pm

Phone: 561-737-8998
DOB: 04/27/1964
Gender: Male

Exam: CT of the Pelvis
CPT Code(s): 72192 - COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL
Laterality:
Clinical: TRAUMA,MVA GROIN PAIN INTO LT LEG

INDICATIONS: Abdominal pain

PROCEDURE: Multi-slice thin axial images were obtained through the pelvis. No contrast was administered.

FINDINGS: The visualized bowel and associated bowel mesentery are normal. No free fluid is noted within the pelvis. No inguinal lymphadenopathy is identified. No masses are present. Prostatic calcifications are noted. The visualized osseous structures are intact without lytic or blastic lesions.

CONCLUSION: Bilateral inguinal lymphadenopathy. Otherwise normal CT of the abdomen and pelvis.

Interpreting Radiologist

James V. Zelch, MD
Electronically Signed: 9/26/08 11:02 pm

[illegible]
01 N W 1st Ave
[illegible]ay Beach, FL 33444

Phone: 561-272-4770
Fax: 561-272-0811

To : CARL SALVATI, M.D.
13455 MILITARY TRAIL SUITE A
DELRAY BEACH, FL 33484
Fax: 561-495-5191

Name: SHERIF KODSY
MR #: DD002378
Exam Start: 11/12/08 8:38 pm

Phone: 561-737-8998
DOB: 04/27/1964
Gender: Male

Exam: MRI of the Cervical Spine
CPT Code(s): 72141 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL
Laterality:
Clinical: **723.4** NECK PAIN, RADICULOPATHY S/P MVA

INDICATIONS: This patient has neck pain and upper extremity radiculopathy.

PROCEDURE: A coronal scout series was followed by T1, proton density and T2 weighted imaging sequences in sagittal and axial planes.

FINDINGS:
All vertebral bodies are well maintained in vertical height and have normal signal characteristics. No evidence of fracture or marrow replacement disease. The soft tissues adjacent to the cervical vertebral bodies are normal. No evidence of anterior/paraspinal mass and no paravertebral abnormal process. There are no hemorrhages and no fluid collections.

The spinal canal is normal in appearance with ample subarachnoid fluid surrounding the spinal cord.

Each foramen is widely patent with normal nerve roots traversing the foramen. The lateral recesses are clear at each cervical level.

At C2-C3, there is a normal disc and a normal vertebral segment. No evidence of cord compression or compression/displacement of the exiting nerve root.

At C3-C4, there is a right central disc herniation and right foramen stenosis.

At C4-C5, the thecal sac and nerve root are widely patent. No evidence of cord compression or compression/displacement of the exiting nerve root at this level.

At C5-C6, there is a focal midline disc herniation. There is impression on the dural sac but no cord compression or foramen stenosis.

At C6-C7, there is a left central disc herniation and left foramen stenosis.

At C7-T1, the thecal sac and foramen are widely patent and there is no evidence of cord compression or displacement of the exiting nerve root.

All other aspects of this study are normal.

Delray Diagnostics
101 N W 1st Ave
Delray Beach, FL 33444

Phone: 561-272-4770
Fax: 561-272-0811

To : FARHAN SIDDIQUI, MD
16244 MILITARY TRAIL #650 DELRAY BEACH, FL

Fax 561-638-8874

Name: SHERIF KODSY
MRN #: 00002378
Exam Start: 8/26/08 2:17 pm

Phone: 561-717-8998
DOB: 04/27/1964
Gender: Male

Exam: MRI of the Lumbar Spine
CPT Code(s): 72148 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR, WITHOUT CONTRAST MATERIAL
Laterality:
Clinical: LUMBAR S/S, SP MVA

INDICATIONS: This patient has low back pain and lower extremity radiculopathy

PROCEDURE: Sagittal and axial images were produced following a coronal scout series. The pulse sequences were designed to emphasize T1, T2 and proton density characteristic of tissue. The analysis is spin-echo

FINDINGS:

Vertebral bodies T12 through S2 are studied. The vertebral bodies are well-maintained in vertical height and have normal signal characteristics on T1 and T2 imaging parameters. The study is negative for fracture. There is no evidence of paravertebral mass or paravertebral soft tissue swelling. The aorta, vena cava and adjacent tissues are normal.

No evidence of soft tissue hematoma or soft tissue mass.

Normal signal is demonstrated within the distal thoracic cord and the conus. The nerve roots of the cauda equina flow freely in the normal thecal sac. No abnormal T2 signal from the distal spinal canal.

T12-L1 interspace is normal. The disc is well hydrated and confined to the intervertebral space. No elevation of the posterior longitudinal ligament and no foraminal compromise.

At L1-L2, there is a normal disc with normal signal on T2 analysis. No identifiable disc herniation at this level. The facet joints, thecal sac and foramen are normal.

At L2-L3, the vertebral body endplates are uniform and the disc is well-maintained in vertical heel-to-shin and in signal characteristics. No compression or displacement of the exiting nerve roots and no elevation of the posterior longitudinal ligament.

At L3-L4, the intervertebral disc is herniated. This herniation is broad-based and central. The posterior longitudinal ligament is elevated and there is impression on the dural sac. No foramen stenosis.

At L4-L5, there are normal foramen, normal thecal sac and normal posterior longitudinal ligament. No herniation.

At L5-S1, there is concentric disc bulging. No foramen compromise or thecal sac stenosis.

The upper sacral segments are normal. No evidence of sacral cyst, Tarlov cyst or any other pathology.

CONCLUSION

1 Broad-based central disc herniation at [illegible]
2 Bulging disc at L3-S1

IVZ.bl m.

Interpreting Radiologist

James V. Zeich, MD

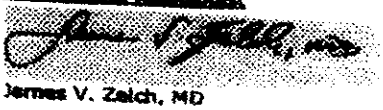
Electronically Signed 9/10/08 9:09 am

CONCLUSION:

1. **Right central disc herniation at C3-C4.**
2. **Midline disc herniation at C5-C6.**
3. **Left central disc herniation at C6-C7.**

JVZ/bt:mj

Interpreting Radiologist



James V. Zelch, MD

Electronically Signed: 11/13/08 4:52 pm

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Medical Director: Daniel E. Rudensky, M.D.
Radiologist: Boca Radiology Group

Patient Name:	**Sherif Kodsy**	**DOB**	04/27/1964	**Phone**	(561) 737-8998
Referring Physician:	Jeffrey A. Zipper	**Fax**	(561) 495-8877		
Date of Exam:	04/16/09	**Pt#**	86218	BOYN	267499

MRI left knee.

HISTORY: Pain and swelling. Meniscal tear.

MR technique: T1 weighted and fat suppressed Turbo T2 weighted 4mm coronal sections, PD and fat suppressed Turbo T2 weighted sagittal and Turbo PD weighted axial sections were obtained.

FINDINGS:

There is small joint effusion. There is edema within the prepatellar and infrapatellar subcutaneous tissues extending about the medial and lateral margins of the knee. There is also edema and thickening along the MCL consistent with a strain or partial tear. No full thickness disruption. Interim posterior cruciate and lateral collateral ligaments intact.

Lateral meniscus demonstrates no morphology and signal characteristics.

There is a horizontal oblique tear within the posterior horn medial meniscus extending to the anterior articular surface . Preservation articular cartilage within all 3 compartments. No evidence for occult fracture or bone bruise. Small exostosis arises from the supracondylar region medial femoral condyle.

IMPRESSION:
1.
1. Strain/ partial tear MCL.
2. Torn posterior horn medial meniscus.
3. Small joint effusion with subcutaneous edema.

Electronically signed by: JOSEPH KLEINMAN, M.D. on 4/16/2009 4:23 PM